TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Eng's Pharmacy, L.L.C.

Respondent Name
Zurich American Insurance Company

MFDR Tracking Number
M4-14-3519-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 29, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "no payment after 1st & 2nd attempt"

Amount in Dispute: $230.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier disputes the pharmacy billings."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 27, 2014	Prescription Medications	$230.60	$230.55

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.10 sets out the procedures for completing a medical bill.
3. 28 Texas Administrative Code §133.20 sets out the procedures for submission of a medical bill.
4. 28 Texas Administrative Code §133.240 sets out the procedures for reimbursing or denying medical bills.
5. 28 Texas Administrative Code §134.503 sets out the guidelines for billing and reimbursing pharmaceutical benefits.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   No Explanations of Benefits were found in the submitted documentation.

Issues

1. Was a complete medical bill submitted in accordance with 28 Texas Administrative Code §§133.10 and 133.20?
2. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.10 sets out the procedures for completing a medical bill. 28 Texas Administrative Code §133.20 sets out the procedures for submitting a medical bill. Review of the submitted documentation finds that the preponderance of evidence supports that a complete medical bill was submitted in accordance with the procedures outlined in 28 Texas Administrative Code §§133.10 and 133.20.
2. The MAR in for the disputed services is established by the AWP formula pursuant to 28 Texas Administrative Code §134.503 (c), which states, in relevant part:

    (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
    (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
    (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount…
    (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
    (A) health care provider

    The requestor is seeking reimbursement for the generic drug cephalexin 500 mg capsule, NDC number 00143989701; meloxicam 15 mg tablet, NDC number 61442012710; and hydrocodon-APAP 10-325 mg, NDC number 00603388721. The disputed medications were dispensed on January 27, 2014. The MAR is calculated as follows:

Date of Service	Prescription Drug	Calculation per §134.503 (c)(1)	§134.503 (c)(2)	Lesser of §134.503 (c)(1) & (2)	Carrier Paid	Balance Due
1/27/14	Cephalexin 500 mg capsule	(1.34750 x 9 x 1.25) + $4.00 = $19.16	$19.20	$19.16	$0.00	$19.16
1/27/14	Meloxicam 15 mg tablet	(4.25870 x 30 x 1.25) + $4.00 = $163.70	$163.70	$163.70	$0.00	$163.70
1/27/14	Hydrocodon-APAP 10-325 mg	(0.69900 x 50 x 1.25) + $4.00 = $47.69	$47.70	$47.69	$0.00	$47.69

3. 28 Texas Administrative Code §133.240 (a) states, “An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.” Review of the submitted documentation does not support that the insurance carrier took final action on the submitted bill or indicate a reason for non-payment of the disputed services. Therefore, reimbursement is recommended. The total MAR for the disputed services is $230.55. This is the recommended amount for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $230.55.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $230.55 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	July 29, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.